TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Memorial Compounding Pharmacy

Respondent Name
New Hampshire Insurance Company

MFDR Tracking Number
M4-17-3708-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
August 18, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We have submitted our request for reconsideration and appeal for the above date of service and have not received payment. There is no prior authorization required…"

Amount in Dispute: $264.97

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Coventry has reviewed the medical billing and have stated that Express Scripts is trying to recoup money owed to them by the dispensing pharmacy. In this case this would be Memorial Compounding Pharmacy. The only way to get this resolved is to have the dispensing pharmacy contact Express Script's pharmacy help line…"

Response Submitted by: Gallagher Bassett

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 30, 2016	Acetaminophen/codeine #4	$103.86	$61.95
December 30, 2016	Tizanidine HCl	$161.11	$157.85

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.503 sets out the fee guidelines for pharmaceutical services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 10 (109) – Claim not covered by this payer/contractor. You must send the claim to the correct payer contractor.
   - 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.

- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- 91 (23) – The impact of prior payer(s) adjudication including payments and/or adjustments.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 86 (18) – Duplicate claim/service.

Issues

1. Did New Hampshire Insurance Company maintain a denial of liability for the disputed services?
2. Did New Hampshire Insurance Company support a denial of payment for the disputed services?
3. Is Memorial Compounding Pharmacy (Memorial) entitled to reimbursement for the disputed services?

Findings

1. Memorial is seeking reimbursement of $264.97 for Acetaminophen/codeine #4 and Tizanidine HCl dispensed on December 30, 2016. On an undated Explanation of Benefits, Gallagher Bassett denied the disputed services on behalf of New Hampshire Insurance Company with claim adjustment reason code 10 (109) – "CLAIM NOT COVERED BY THIS PAYER/CONTRACTOR. YOU MUST SEND THE CLAIM TO THE CORRECT PAYER/CONTRACTOR."

   Gallagher Bassett did not include this denial on subsequent Explanations of Benefits or discuss this denial in its position statement for this dispute. The division concludes that New Hampshire Insurance Company did not maintain a denial of liability for the disputed services.

2. On an Explanation of Benefits dated April 24, 2017, Gallagher Bassett denied the services in question with claim adjustment reason code 91 (23) – "The impact of prior payer(s) adjudication including payments and/or adjustments." Further, Gallagher Bassett argued in its position statement on behalf of New Hampshire Insurance Company, "Coventry has reviewed the medical billing and have stated that Express Scripts is trying to recoup money owed to them by the dispensing pharmacy."

   The submitted documents do not support a prior payment or "prior payer(s) adjudication." Therefore, the division finds that this denial is not supported. The disputed services will be reviewed in accordance with applicable fee guidelines.

3. 28 Texas Administrative Code §134.503 applies to the services in dispute and states, in pertinent part:

   (c) The insurance carrier shall reimburse the health care provider or pharmacy processing agent for prescription drugs the lesser of:
   (1) the fee established by the following formulas based on the average wholesale price (AWP) as reported by a nationally recognized pharmaceutical price guide or other publication of pharmaceutical pricing data in effect on the day the prescription drug is dispensed:
   (A) Generic drugs: ((AWP per unit) x (number of units) x 1.25) + $4.00 dispensing fee per prescription = reimbursement amount;
   (B) Brand name drugs: ((AWP per unit) x (number of units) x 1.09) + $4.00 dispensing fee per prescription = reimbursement amount;
   (C) When compounding, a single compounding fee of $15 per prescription shall be added to the calculated total for either paragraph (1)(A) or (B) of this subsection; or
   (2) notwithstanding §133.20(e)(1) of this title (relating to Medical Bill Submission by Health Care Provider), the amount billed to the insurance carrier by the:
   (A) health care provider; or
   (B) pharmacy processing agent only if the health care provider has not previously billed the insurance carrier for the prescription drug and the pharmacy processing agent is billing on behalf of the health care provider.

The reimbursement for the services in question is calculated below:

Drug	NDC & Type	Price/Unit	Total Units	AWP Formula §134.503(c)(1)	Billed Amt §134.503 (c)(2)	Lesser of (c)(1) and (c)(2)
Acetaminophen/ codeine tablets	00093035005 Generic	$0.55186	84	$61.95	$103.86	$61.95
Tizanidine HCl tablets	60505025202 Generic	$1.46524	84	$157.85	$161.11	$157.85

The total allowable for the disputed services is $219.80. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $219.80.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor $219.80, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Laurie Garnes	October 13, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.